

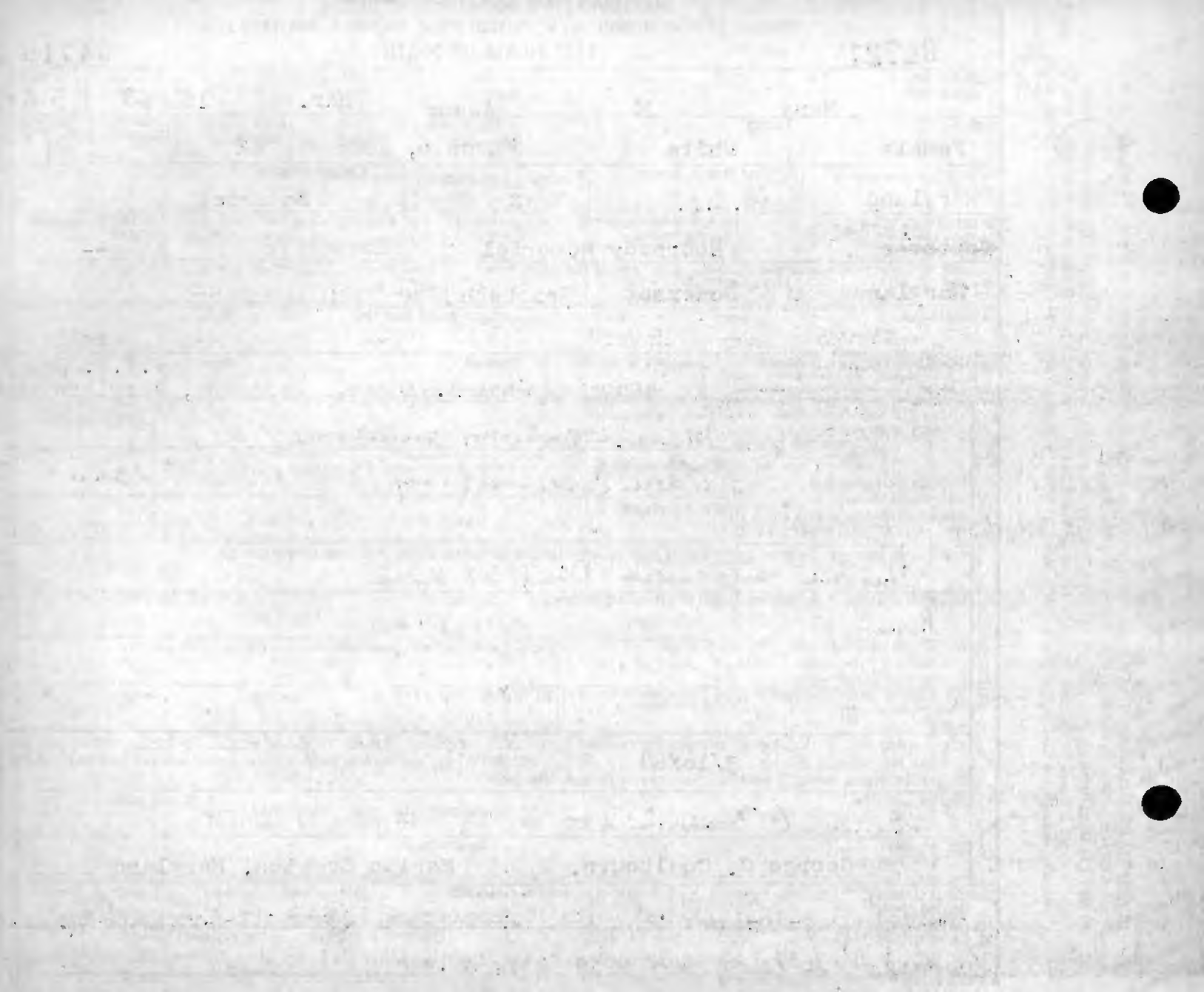
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Mary M Adams</b>			2a. DATE OF DEATH Month <b>Mar.</b> Day <b>16</b> Year <b>68</b>			2b. HOUR <b>5 A M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 6, 1886</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Somerset</b> Md.			
10. CITY OR TOWN OF DEATH <b>Westover</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>McCreedy Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Rehobeth</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>--</b>	
14. FATHER'S NAME First Middle Last <b>Steven -- Howard</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>-- -- Tull</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Carl E. Adams, Westover, Maryland</b>		Address <b>R.F.D. 1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Masary Pulmonary Hemorrhage</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163 Chronic myocarditis Chronic Intest. ulcers</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3 14</b> , 19 <b>66</b> , to <b>3 16</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>3/16/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George C. Coulbourn M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M.D.</b>						22e. ADDRESS <b>Marion Station, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-18-1968</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Rehoboth Presbyterian</b>		23d. LOCATION (City or Town) (County) (State) <b>Rehobeth-Somerset-Md.</b>			
24. FUNERAL DIRECTOR <b>Robert H. Watson</b> ADDRESS <b>Pocomoke City, Md.</b>				25a. REC'D BY REGISTRAR <b>Charles Young</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Young</b> DATE <b>MAR 21 1968</b>			



CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)			First <b>ARTEMAS</b>			Middle <b>REESE</b>			Last <b>BETTS</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR <b>2:00A.M.</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Nov. 4, 1893</b>			6. AGE (In years lost birthday) <b>74</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Delaware</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Somerset</b>			Md.					
10. CITY OR TOWN OF DEATH <b>Crisfield</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>14 Potomac St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Executive</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Cutlery Mfg.</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Somerset</b>			13c. CITY OR TOWN <b>Crisfield</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>14 Potomac St.</b>					
14. FATHER'S NAME First <b>Artemas</b> Middle <b>W.</b> Last <b>Betts</b>			15. MOTHER'S MAIDEN NAME First <b>Eleanor</b> Middle <b>Green</b> Last <b>Green</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT <b>Mrs. Flossie D. Betts - same as 13 above</b>			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure - Pulmonary edema</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>1 year</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>443X</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1968</b> , to <b>Mar 31, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Sarah M. Peyton M.D.</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>4/2/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M.D.</b>			22e. ADDRESS <b>Main St. - Crisfield, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>April 3, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Crisfield- Somerset- Md.</b>								
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons - Crisfield, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>APR 5 - 1968</b>			25b. REGISTRAR'S SIGNATURE <b>R Charles Judge</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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EDC-ET + urea = 0.26; EDC-ET + urea + NaOH = 0.28

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |   |  |  |  |                        |  |
|--|---------|------------------------------|--|--|---|--|--|--|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |  |   |  |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR   |                        |  |
| MARY PARKS BRITTINGHAM   |         |                              |  |  |   | ESTIMATED <input type="checkbox"/> MONTH DAY YEAR                                      |  | M  |                        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD   |                        |  |
| FEMALE   | WHITE   | FEB. 20, 1908                | 60 YRS   | MONTHS   | DAYS  | HOURS  | MIN.   | Month Day Year   | 2d. HOUR               |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | Md.  |                        |  |
| MARYLAND   |         | U.S.A.                       |  |  |   | SOMERSET   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |  |
| WESTOVER   |         |                              | AT HOME  |  |   | SEAMSTRESS   |  | CLOTHING   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MD   |         |                              | SOMERSET   |  | WESTOVER  |  |  |  |                        |  |
| 14. FATHER'S NAME First Middle Last  |         |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |  |  |  |                        |  |
| JAMES PARKS  |         |                              | EMMA FORD  |  |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |                        |  |
|  |         |                              |  |  | PAUL H. BRITTINGHAM   |  | WESTOVER, MD.  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |                        |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction  |         |                              |  |  |   |  |  | seconds  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary arteriosclerosis   |         |                              |  |  |   |  |  | years  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |         |                              |  |  |   |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |   |  |  |  |                        |  |
| 4201 had colostomy, Crisfield Hospital, recently for ca.   |         |                              |  |  |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |  |  |  |                        |  |
| ACTUAL SIGNATURE   |         |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |   |  |  | 22b. DATE SIGNED   |                        |  |
| EXAMINER'S NAME (Type)   |         |                              | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |  |   |  |  | 3-16-68  |                        |  |
| Everett Sutter MD  |         |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |   |  |  | ADDRESS (Street, city, town, or county)  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                        |  |
| BURIAL   |         |                              | 3/17/1968  |  | FAIRMOUNT CEMETERY  |  | FAIRMOUNT, MD.   |  |                        |  |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS  |  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                        |  |
| LEVIN R. WILSON  |         |                              | PRINCESS ANNE, MD.   |  |   | DATE MAR 20 1968   |  | Charles Judge  |                        |  |



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                         |  |  |   |  |  |   |  |  |
|--|-------------------------|--|--|---|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>George Lee A. Dix</b>   |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Mar.</b> Day <b>17</b> Year <b>1968</b> |   |  | 2b. HOUR <b>11A</b>  |   |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br><b>Mar. 19, 1911</b>   | 6. AGE (In years last birthday)<br><b>56</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  | IF UNDER 24 HRS<br>HOURS _____ MIN _____   | 2c. DATE PRONOUNCED DEAD<br>Month <b>Mar.</b> Day <b>17</b> Year <b>1968</b>             |   | 2d. HOUR <b>11A</b>  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Somerset</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Princess Anne</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Beekford Ave.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired.)<br><b>Freighting</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                         | 13b. COUNTY <b>Somerset</b>  |  | 13c. CITY OR TOWN <b>Princess Anne</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Beekford Ave.</b>                 |  |
| 14. FATHER'S NAME<br><b>George Lee Dix</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br><b>Lottie Milliner</b>   |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |   | 17. INFORMANT<br><b>Mrs. Ida Lee Dix, Princess Anne, Md.</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>coronary arteriosclerosis</b>                                   |                         |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |                         |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b>                                       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                              |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |  | 21f. LOCATION Street or R.F.D. No. _____  |  | City or Town _____   |   | County _____ State _____                                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Everett Sutter</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED<br><b>3-20-68</b>   |   |  |  |
| EXAMINER'S NAME (Type) <b>Everett Sutter MD</b>  |                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  | ADDRESS (Street, city, town, or county) <b>Somerset</b>                                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                         | 23b. DATE<br><b>3/20/1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beechwood</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Princess Anne; Somerset; Md.</b>     |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>James D. ...</b>  |                         |  | ADDRESS<br><b>Princess Anne</b>  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 27 1968</b>                                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>             |  |

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[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some faint words like "The", "and", "of" are visible.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |   |                |   |   |   |                             |  |                                   |
|--|--|---|----------------|---|---|---|-----------------------------|--|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>Merriabel  | Middle<br>Jane | Last<br>Franklin  | 2a. DATE OF DEATH<br>Month <u>27</u> Day <u>28</u> Year <u>68</u> |   | 2b. HOUR<br><u>3:45</u> P M |  |                                   |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |                | 5. DATE OF BIRTH<br>Feb. 22, 1895   |   | 6. AGE (In years last birthday)<br>73 YRS.  |                             | IF UNDER 1 YEAR<br>MONTHS<br>DAYS          | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Somerset  |                             |  |                                   |
| 10. CITY OR TOWN OF DEATH<br>Crisfield   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>McCreedy Memorial |                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home  |                             |  |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Somerset   |                | 13c. CITY OR TOWN<br>Crisfield  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             | 13e. STREET AND NUMBER<br>11 Franklin Lane |                                   |
| 14. FATHER'S NAME<br>First<br>Joseph   |  | Middle<br>Parker  |                | Last<br>Parker  |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Mary   |                             | Middle<br>Etta                             |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>No  |  | (If yes give war or dates of service)   |                | 16b. SOCIAL SECURITY NO.<br>None  |   | 17. INFORMANT<br>Address<br>Miss Margaret Franklin- same as 13 above                            |                             |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>relativer mellitus</u><br>2509<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>yes</u> |  |   |                |   |   |   |                             |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>260X  |  |   |                |   |   |   |                             |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                             |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                             |  |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |                | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |                             | County State                               |                                   |
| 22a. I certify that (I) ( <del>this</del> hospital) attended the deceased from _____, 19 <u>46</u> , to _____, 19 <u>68</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>3-28-68</u> 19____, and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.    |  |   |                |   |   |   |                             |  |                                   |
| 22b. SIGNATURE<br><u>C. G. Rawley</u>  |  |   |                | DEGREE<br>ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                |   | 22c. DATE SIGNED<br><u>3-29-68</u>  |                             |  |                                   |
| 22d. PHYSICIAN'S NAME (Type)<br>C. G. Rawley, M.D.   |  |   |                | 22e. ADDRESS<br>Crisfield, Maryland   |   |   |                             |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>March 30, 1968   |                | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunnyridge Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Crisfield- Somerset -Md.                       |                             |  |                                   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Bradshaw & Sons -- Crisfield, Md.   |  |   |                | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 1 - 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Johnas J. J...</u>   |                             |  |                                   |

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## References

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

Figure 4

990 21 11 1992 - 2 1/2 in. Jaws 1000 1000

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14-33700-101110

[illegible]

Figure 2

• 1970-1980 -- 2000 -- 2010

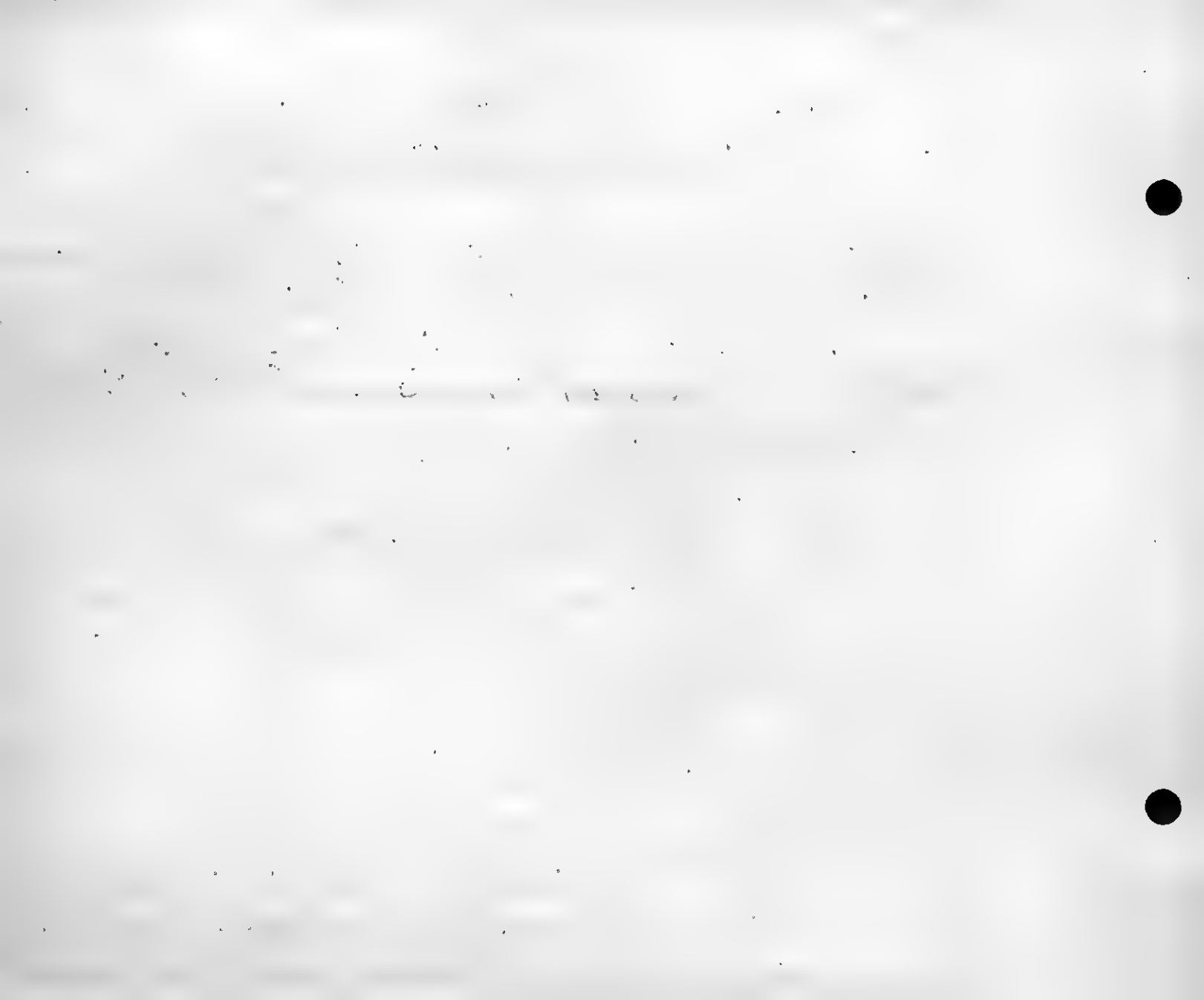
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |   |   |   |  |  |  |                                       |  |
|---|---|---|---|--|--|--|---------------------------------------|--|
| 1 DECEASED-NAME<br>(Type or print)  |   | First   | Middle  | Last   | 2a. DATE OF DEATH<br>Mar. Month Day Year   |  | 2b. HOUR                              |  |
| Melvin  |   |   |   | Jackson  | Mar. 5 68  |  | 5:40                                  |  |
| 3 SEX   | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6 AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |  |
| Male  | Negro   |   | 1/10/1913   |  | 35 YRS.  |  |                                       |  |
| 7a BIRTHPLACE (State or foreign country)  | 7b CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                       |  |
| SOMERSET  | U.S.  |   |   |  | Somerset County Md.  |  |                                       |  |
| 10 CITY OR TOWN OF DEATH  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                       |  |
| Crisfield   | McCreedy Memorial   |   | LABORER   |  | BEAFOED  |  |                                       |  |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE   | 13b. COUNTY   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                |  |
| Md.   | Somerset  |   | MARION  |  |  |  | Rural                                 |  |
| 14 FATHER'S NAME First Middle Last  |   |   | 15 MOTHER'S MAIDEN NAME First Middle Last   |  |  |  |                                       |  |
| Unknown   |   |   | Donah Jackson   |  |  |  |                                       |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |   |   | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT Address   |  |                                       |  |
| No  |   |   | 222-05-4647   |  | DAVID Johnson (Brother) Marion   |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Chronic Ischemic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Ischemic Heart Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>General Arteriosclerosis</u> <u>Myocardial Infarction</u> |   |   |   |  |  |  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                       |  |
|   |   |   |   |  |  |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                                       |  |
|   |   |   |   |  |  |  |                                       |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |                                       | State  |
|   |   |   |   |  |  |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1.3 68, 19, to Feb 5, 1968, that (I) (we) last saw the deceased alive on Mar. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |  |                                       |  |
| 22b. SIGNATURE <u>George C. Coulbourn M.D.</u>  |   |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |                                       |  |
|   |   |   |   |  |  |  |                                       |  |
| 22d. PHYSICIAN'S NAME (Type)  |   | G, C, Coulbourn, M.D.   |   | 22e. ADDRESS Crisfield, Md.  |  |  |                                       |  |
|   |   |   |   |  |  |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)                        |                                       |  |
| Burial  |   | 3/8/68  |   | Marumsee   |  | Rehoboth Md  |                                       |  |
| 24. FUNERAL DIRECTOR  |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                       |  |
| Anthony E. Ward Crisfield Md.   |   |   |   | MAR 12 1968  |  | Charles Jones  |                                       |  |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

|  |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
|--|--------|------------------------------|---|--|-----------------------------------|--|---|-----------------------------|---|------------------|--|---------|
| 1 DECEASED NAME<br>(Type or Print)   |        |                              | First   | Middle   | Last                              | 2a. DATE KNOWN OF DEATH  |   |                             | <input checked="" type="checkbox"/> Month                           | Day              | Year   | 2b HOUR |
| Georgia Anna Jones   |        |                              |   |  |                                   | 3-10-68  |   |                             |   |                  | 19   | 10AM    |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH              | 6 AGE (In years last birthday)  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS  |   | 2c DATE PRONOUNCED DEAD     |   |                  | 2d HOUR                                      |         |
| F  | C      | 9-12-1892                    | 75 YRS  | MONTHS   | DAYS                              | HOURS  | MIN   | 3-10-68                     |   |                  | 11:45 AM                                     |         |
| 7a BIRTHPLACE (State or foreign country)   |        | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH   |   |                             | Md  |                  |  |         |
| North Carolina   |        | USA                          |   |  |                                   | Somerset   |   |                             |   |                  |  |         |
| 10. CITY OR TOWN OF DEATH  |        |                              | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                   | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |                             | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                  |  |         |
| Princess Anne  |        |                              |   |  |                                   | retired  |   |                             | retired   |                  |  |         |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution)  |        |                              | 13b COUNTY  |  | 13c CITY OR TOWN                  |  | 3d INS DE CITY LIMITS?  |                             | 13e STREET AND NUMBER   |                  |  |         |
| Maryland   |        |                              | Somerset  |  | Princess Anne                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             | Hampton Ave   |                  |  |         |
| 14 FATHER'S NAME   |        |                              | First   | Middle   | Last                              | 15 MOTHER'S MAIDEN NAME  |   |                             | First   | Middle           | Last   |         |
| Edward Mackie  |        |                              |   |  |                                   | Harriett Blunt   |   |                             |   |                  |  |         |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or Unknown)   |        |                              | 16b SOCIAL SECURITY NO.   |  |                                   | 17. INFORMANT  |   |                             | ADDRESS   |                  |  |         |
| no   |        |                              |   |  |                                   | Virginia George  |   |                             | Wilmington, Del   |                  |  |         |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |        |                              |   |  |                                   |  |   |                             |   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon Monoxide intoxication</u>   |        |                              |   |  |                                   |  |   |                             |   |                  | 2-3 hours                                    |         |
| 8774X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
| (b) <u>oil burner near bed</u>   |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
| DUE TO, OR AS A CONSEQUENCE OF   |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
| (c)  |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
| 19a. DATE OF OPERATION   |        |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  |                                   |  |   |                             | 20. AUTOPSY?  |                  |  |         |
|  |        |                              |   |  |                                   |  |   |                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |  |         |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |        |                              | 21b TIME OF INJURY Month Day Year   |  |                                   | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8.)          |   |                             |   |                  |  |         |
|  |        |                              | 12 midnight   |  |                                   | was sleeping near oil burner and William 3-10-68 which was not vented                  |   |                             |   |                  |  |         |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |        |                              | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                   | 21f LOCATION Street or RFD No  |   |                             | City or town  |                  | County State                                 |         |
|  |        |                              | home  |  |                                   | Hampton Ave, Princess Anne, Somerset, Md.  |   |                             |   |                  |  |         |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        |                              |   |  |                                   |  |   |                             |   |                  |  |         |
| ACTUAL SIGNATURE   |        |                              | CHIEF MEDICAL EXAMINER  |  |                                   |  |   |                             | 22b. DATE SIGNED  |                  |  |         |
| EXAMINER'S NAME (Type)   |        |                              | Everett Sutter MD   |  |                                   |  |   |                             | 3-14-68   |                  |  |         |
| 23a BURIAL, CREMATION REMOVAL (Specify)  |        |                              | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY |  |   | 23d LOCATION (City or Town) |   | (County) (State) |  |         |
| Burial   |        |                              | 3-16-68   |  | Isreal Moneral                    |  |   | Princess Anne, Somerset     |   | Maryland         |  |         |
| 24 FUNERAL DIRECTOR  |        |                              | ADDRESS   |  |                                   |  |   |                             | 25a REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE                   |         |
| William H James Jr, Princess Anne, Md  |        |                              |   |  |                                   |  |   |                             | MAR 15 1968   |                  |  |         |

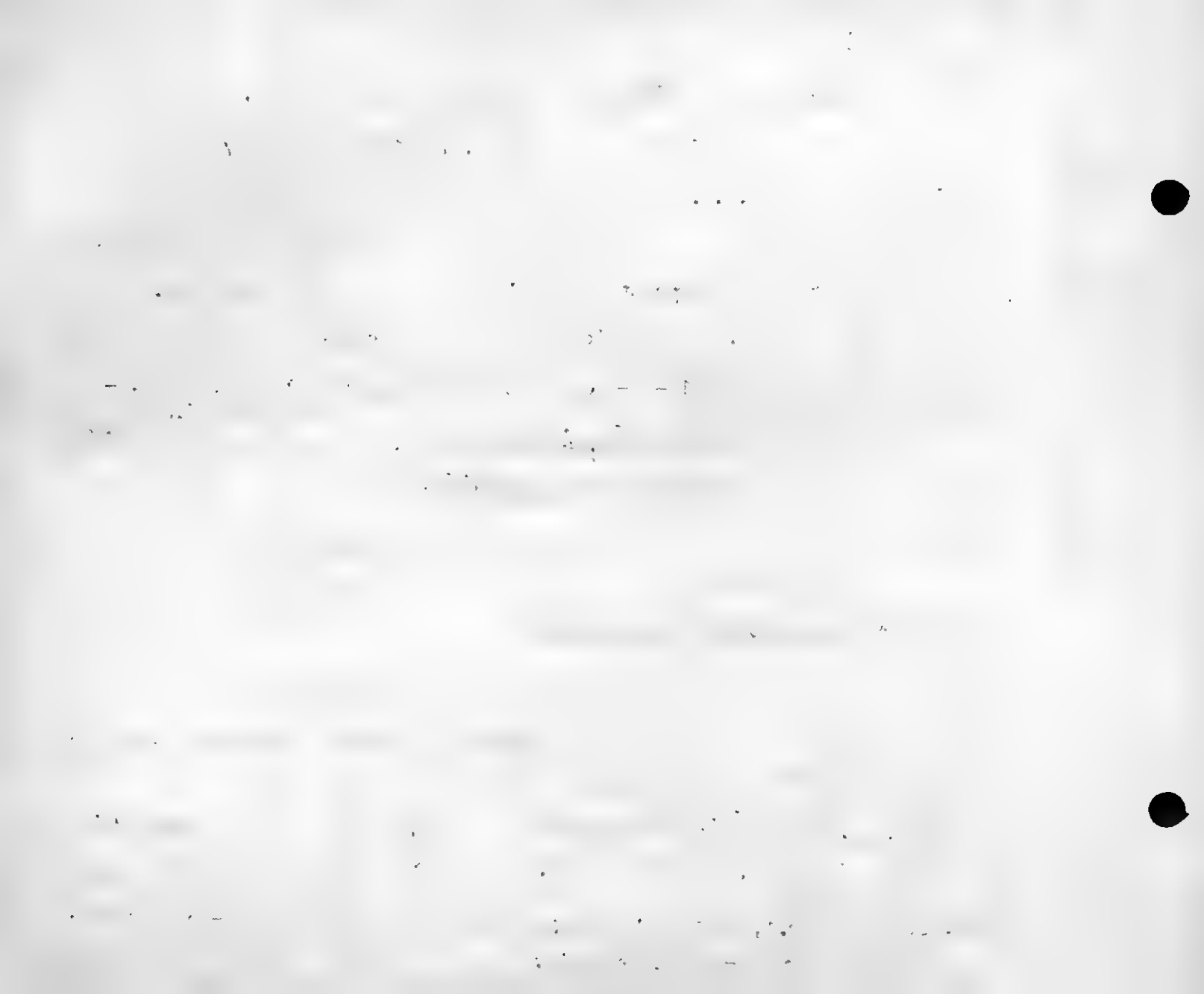




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |   |  |  |  |  |                                     |  |
|---|--|--|--|--|--|--|--|--|---|--|--|--|--|-------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |   |  |  |  |  |                                     |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                     |  |
| 1 DECEASED NAME<br>(Type or print)  |  |  | First<br><b>JOHN</b>   |  |  | Middle<br><b>TUBMAN</b>  |  |  | Last<br><b>JUSTICE</b>  |  |  | 2a DATE OF DEATH<br>Month <b>Mar.</b> Day <b>29</b> Year <b>68</b> |  | 2b HOUR<br><b>8:15</b> MIN <b>P</b> |  |
| 3 SEX<br><b>Male</b>  |  |  | 4 RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>Aug. 13, 1890</b>   |  |  | 6 AGE (In years<br>lost birthday)<br><b>77</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                     |  | IF UNDER 24 HRS.<br>HOURS MIN.      |  |
| 7a BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Somerset</b> Md.   |  |  |  |  |                                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>Crisfield</b>  |  |  | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>McCreedy Hospital</b> |  |  | 12a USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Carpenter</b>  |  |  | 12b KIND OF BUSINESS OR<br>INDUSTRY<br><b>Construction</b>                                  |  |  |  |  |                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>Somerset</b>  |  |  | 13c. CITY OR TOWN<br><b>Crisfield</b>  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e STREET AND NUMBER<br><b>13 Walnut St.</b>                      |  |                                     |  |
| 14 FATHER'S NAME<br>First <b>Edward</b> Middle <b>T.</b> Last <b>Justice</b>  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Ellen</b> Last <b>Parks</b>                       |  |  |  |  |  |   |  |  |  |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes (no, or unknown) <b>NO</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO<br><b>217-03-1467</b>  |  |  | 17. INFORMANT<br>Address<br><b>Ralph Justice - 127 Richardson Ave. -</b>   |  |  |   |  |  |  |  |                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>5/1/68 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>Acute Pericarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>7 days</b> |  |  |  |  |  |  |  |  |   |  |  |  |  |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)<br><b>5/1/68 Diabetes</b>  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                     |  |
| 19a DATE OF OPERATION<br><b>3-18-68</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intestinal Obstruction</b>                          |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                     |  |  |  |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |  |  |  |                                     |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |  |  |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 19 <b>68</b> , to <b>3-29</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>3/29/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |   |  |  |  |  |                                     |  |
| 22b. SIGNATURE<br><b>James A. Sterling, M.D.</b>  |  |  | DEGREE   |  |  | ATTENDING<br>PHYS <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS <input type="checkbox"/>                     |  |  | 22c. DATE SIGNED<br><b>4/1/68</b>   |  |  |  |  |                                     |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>James A. Sterling, M.D.</b>   |  |  | 22e. ADDRESS<br><b>Crisfield, Maryland</b>   |  |  |  |  |  |   |  |  |  |  |                                     |  |
| 23a. BURIAL, CREMAT-ON,<br>REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Apr. 1, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnyridge Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Crisfield-Somerset-Md.</b>              |  |  |  |  |                                     |  |
| 24. FUNERAL DIRECTOR<br><b>Bradshaw &amp; Sons - Crisfield, Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 3 - 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |  |  |  |  |                                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(Type or print) <b>HARRY BUDD MILES</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>6</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>9 P. M.</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>JAN..15, 1877</b>  |  | 6. AGE (In years last birthday)<br><b>91</b> YRS.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>SOMERSET CO.</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>UPPER FAIRMOUNT</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>AT HOME</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>UNDER TAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>SOMERSET</b>   |   | 13c. CITY OR TOWN<br><b>UPPER FAIRMOUNT</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>DANIAL MILES</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>LEAH HALL</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address<br><b>MRS ELIZABETH MILES UPPER FAIRMOUNT, MD.</b>                    |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Dementia</b> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 yrs.</b><br><b>15 yrs.</b><br><b>15 yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>422.1</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                              |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1956</b> , to <b>Mar 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>A.C. Lewis, M.D.</b> DEGREE   |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>3-7-68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>A. C. Lewis, M.D.</b>   |  | 22e. ADDRESS<br><b>Princess Anne, Md.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/9/1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ODD FELLOWS CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>SEAFORD, DEL.</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>LEVIN R. WILSON</b>   |  |  |   | ADDRESS<br><b>PRINCESS ANNE, MD.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 11 1968</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |   |   |  |  |  |





FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |         |  |
|--|--|--|--|---|--|---|--|---|---------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |         |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH   |         | 2b. HOUR                                     |
| ETHRIAM  |  | Taylor   |  |   |  |   |  | Month   | Day     | Year   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | 7c. DATE PRONOUNCED DEAD  |         | 7d. HOUR                                     |
| M  |  | Negro  |  | 1/10/1906   |  | 62 YRS.   |  | Month   | Day     | Year   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | 9. COUNTY OF DEATH  |  |   |         |  |
| Crisfield  |  | U.S.   |  | WIDOWED   |  | SOMERSET  |  |   |         |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |         |  |
| Crisfield Md   |  | McCreedy Hosp.   |  | LABORER   |  |   |  |   |         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |         |  |
| Md   |  | SOMERSET   |  | Crisfield   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | M. 416 St.  |         |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |         |  |
| Henry Taylor   |  | Harriet Spence   |  |   |  |   |  |   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |         |  |
| No   |  | 217-03-7879  |  | Charlotte Taylor  |  | MARION MD.  |  |   |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |   |         |  |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION  |  |  |  |   |  |   |  |   |         | FEW MO.                                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |         |  |
| (b) GENERALIZED ARTERIOSCLEROSIS   |  |  |  |   |  |   |  |   |         | UNKNOWN                                      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |         |  |
| (c)  |  |  |  |   |  |   |  |   |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |   |         |  |
| EXPOSURE   |  |  |  |   |  |   |  |   |         |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |   |  | 20. AUTOPSY?  |         |  |
|  |  |  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |         |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY Month, Day, Year  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |         |  |
|  |  |  |  | HOUR A.M. P.M. 19   |  |   |  |   |         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  | State   |  |
|  |  |  |  |   |  |   |  |   |         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |   |         |  |
| ACTUAL SIGNATURE   |  |  |  | CHIEF MEDICAL EXAMINER  |  |   |  | 22b. DATE SIGNED  |         |  |
| A. N. BARR, M.D.   |  |  |  | ASSISTANT MEDICAL EXAMINER  |  |   |  | 3/5/68  |         |  |
| EXAMINER'S NAME (Type)   |  |  |  | DEPUTY MEDICAL EXAMINER   |  |   |  | ADDRESS (Street, city, town, or county)                             |         |  |
| A. N. BARR, M.D.   |  |  |  |   |  |   |  |   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)  | (State) |  |
| Burial   |  | 3/5/68   |  | Asbury Cem.   |  | Crisfield   |  |   | Md      |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |         |  |
| Anthony E. Ward  |  |  |  | Crisfield Md.   |  | MAR 18 1968   |  |   |         |  |

04750

04750

Generalized Anesthesia  
Route Myocardial Infarction Test

Exposure

A. W. BARK, M.D.  
Gen. An.

3/7/68

x

x